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Form Approved
OMB No. 0920-0020
Expires 02/28/2015

Spirometry Facility Certification Form

NIOSH
Coal Workers' Health Surveillance Program
1095 Willowdale Road, M/S LB208
Morgantown, WV 26505

Facility Name _____ Telephone Number _____

Street Address _____ Email _____

City _____ State _____ Zip Code _____ County _____

Type of Facility (Mobile, Clinic, Private Office, Hospital) _____ How many spirometries per year? _____

Spirometry System(s) Used	Unit #1		Unit #2	
Room Number (if applicable)	_____		_____	
Manufacturer	_____		_____	
Model	_____		_____	
Serial #	_____		_____	
Date acquired	_____		_____	
Spirometer Validation Letter* (attached)	☐ Yes		☐ Yes	
Automated Quality Control*	☐ Yes		☐ Yes	
Calibration Check Available*	☐ Yes		☐ Yes	
Graphical Displays				
Meet 2005 ATS/ERS size standards*	☐ Volume-Time	☐ Flow-Volume	☐ Volume-Time	☐ Flow-Volume
Real-time during testing*	☐ Volume-Time	☐ Flow-Volume	☐ Volume-Time	☐ Flow-Volume
Test Report for Interpreter* (sample attached)	☐ Yes		☐ Yes	
Spirometry data file				
Stores 2005 ATS/ERS parameters*	☐ Yes		☐ Yes	
Stores all maneuvers	☐ Yes	☐ if No, max # ___	☐ Yes	☐ if No, max # ___
Electronic Output Format*	☐ 2005 ATS/ERS	☐ NIOSH-approved	☐ 2005 ATS/ERS	☐ NIOSH-approved

***Items indicated by asterisk are required**

Spirometry procedure manual available in laboratory ☐ Yes (mo/yr revised _____) ☐ No

Ongoing spirometry quality assurance program ☐ Yes (mo/yr revised _____) ☐ No

Height Measurement Device ☐ Stadiometer (brand) _____ ☐ Other _____

Weight Measurement Device ☐ Medical scale (brand) _____ ☐ Other _____

Name(s) of Spirometry Technologist(s)	Copy of NIOSH-Approved Spirometry Certificate attached
_____	☐ Yes
_____	☐ Yes
_____	☐ Yes
_____	☐ Yes

I agree to participate in this program in the manner specified by Part 37 of the Code of Federal Regulations (42 CFR Part 37), and understand that all information used in connection with this program will be held STRICTLY CONFIDENTIAL and divulged only as specified by the above Regulation.

Supervising Clinician (copy of license attached)	Signature	Date Signed
_____	_____	_____

Clinician certification or specialized spirometry training Institution	Title of course or certification	Date completed
_____	_____	_____

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